UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

NEUPOGEN / NEULASTA / LEUKINE

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext and options_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY TO (801) 536-0477

CRITERIA:

- **DOCUMENTED:** myelosuppressive chemotherapy, bone marrow transplant, peripheral blood progenitor cell collection, severe chronic neutropenia; OR
- Documented ANC < 750 cells/microliter in patients with Hepatitis C who are being treated with Interferon.

NOT COVERED FOR:

AIDS, Hairy cell leukemia, Myelodysplasia, drug induced congenital agranulocytosis, Alloimmune neonatalneuropenia

AUTHORIZATION:

6 months

RE-AUTHORIZATION:

Telephone request from physician's office or pharmacy.